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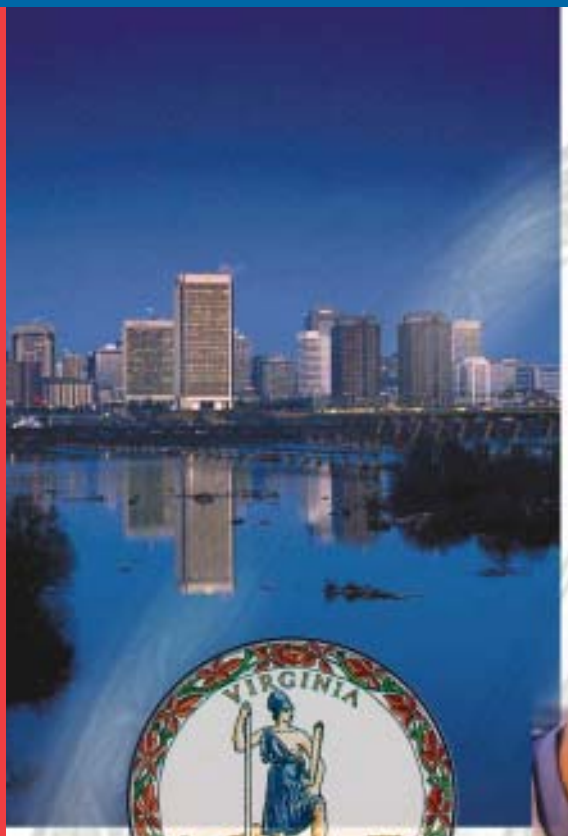

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Southern Health Services
(CareNet)

SFY 2005

We don't provide healthcare... we make it better.

Section I - Operational Systems Review

Introduction

The operational systems review provides an assessment of the structure, process, and outcomes of the MCO's internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, as part of the calendar year (CY) 2004 review, Delmarva evaluated the following systems:

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems—Subpart F Regulation

It is expected that each MCO will utilize the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Methodology

The operational systems standards used in the calendar year (CY) 2004 review were the same as those used in the 2003 review period (June through December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, in regards to the BBA, these standards include regulations under Subpart C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "not met." Each element that was not fully met in the 2003 review was assessed as part of the calendar year (CY) 2004 review.

The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or not met in the 2003 review. This approach required Delmarva staff to conduct an evaluation of changes to policies, procedures, staff, and processes made by the MCO since the last review. The Delmarva team assessed all documentation provided by the MCO to assess whether or not the MCO' had the administrative and operational systems in place and had implemented key operational policies and procedures to meet statutory requirements. During the process, the reviewers requested and the MCOs were asked to provide additional documentation or clarification where questions or concerns were identified.

As in the 2003 review, Delmarva review staff conducted the review, each element within a standard was rated as "met," "partially met," or "not met." Elements were then rolled up to create a determination of "met," "partially met," or "not met" for each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met
Partially Met	At least half the required elements within the standard were met or partially met
Not Met	Less than half the required elements within the standard were met or partially met

The final element rating was determined as follows. All elements that were met in the 2003 review remained met for the CY 2004 review. All elements that were not fully met (partially met or unmet) were reviewed again and the CY 2004 review determination was applied. Therefore, the Operational Systems Review scores for the CY 2004 should increase from the 2003 year if the MCO made efforts to address the elements that were not fully met in the 2003 review.

Results

The overall performance rating for each of the three major standards is found in Table 2.

Table 2. Operational Systems Review Results by Standard – Calendar Year 2004 Results

Performance Standard	Overall Performance Rating
Subpart C- Enrollee Rights and Protections	Partially Met
Subpart D- Quality Assessment and Performance Improvement	Met
Subpart F- Grievance Systems	Partially Met

A total of 47 standards are evaluated as part of the Operational Systems Review. Of the seven (7) Enrollee Rights standards, five (5) were met and only two (2) were partially met. All of the 29 Quality Assessment and Performance Improvement standards were met. Of the 11 Grievance Systems standards eight (8) were fully met and three (3) were partially met. None of the standards received a review determination of not met.

Results for each of the 47 Operational Systems Review elements contain within each of the three standards are presented in Table 3. The number of "Met" review determinations is a cumulative sum; it includes the number of elements met in the 2003 review plus those met in the CY 2004 Review.

Table 3. 2004 On-site Operational Systems Review Results for CareNet.

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
ER 1	Written policies regarding enrollee rights and protections	11/0/0	Met
ER 2	Information provided to enrollees upon enrollment and according to expected time frames	10/0/0	Met
ER 3	Information and language requirements	7/1/0	Partially Met
ER 4	Protected health information	3/0/0	Met
ER 5	Emergency and post-stabilization services	5/0/0	Met
ER 6	Advanced directives	3/1/0	Partially Met
ER 7	Rehabilitation Act, ADA	2/0/0	Met
QA 1	Availability of services: network of appropriate providers	2/0/0	Met
QA 2	Availability of services: direct access to women's health specialist	1/0/0	Met
QA 3	Availability of services: second opinion	1/0/0	Met
QA 4	Availability of services: out of network	1/0/0	Met
QA 5	Cultural considerations	1/0/0	Met
QA 6	Coordination and continuity of care	1/0/0	Met
QA 7	Coordination and continuity of care: additional services for enrollees with special health care needs	1/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
QA 8	Direct access to specialists	2/0/0	Met
QA 9	Referrals and treatment plans	1/0/0	Met
QA 10	Primary care and coordination program	3/0/0	Met
QA 11	Coverage and authorization of services: processing of requests	9/0/0	Met
QA 12	Coverage and authorization of services-: notice of adverse action	1/0/0	Met
QA 13	Time frame for decisions: standard authorization decisions	1/0/0	Met
QA 14	Time frame for decisions: expedited authorization decisions	2/0/0	Met
QA 15	Provider selection: credentialing and recredentialing requirements	3/0/0	Met
QA 16	Provider selection: non-discrimination	1/0/0	Met
QA 17	Provider discrimination prohibited	1/0/0	Met
QA 18	Provider selection: excluded providers	1/0/0	Met
QA 19	Provider enrollment and disenrollment: requested by MCO	1/0/0	Met
QA 20	Provider enrollment and disenrollment: requested by the enrollee	2/0/0	Met
QA 21	Grievance systems	4/0/0	Met
QA 22	Subcontractual relationships and delegation	4/0/0	Met
QA 23	Practice guidelines	4/0/0	Met
QA 24	Dissemination of practice guidelines	1/0/0	Met
QA 25	Application of practice guidelines	1/0/0	Met
QA 26	Quality assessment and performance improvement program	3/0/0	Met
QA 27	Under/over utilization of services	1/0/0	Met
QA 28	Care furnished to enrollees with special health needs	1/0/0	Met
QA 29	Health/management information systems	5/0/0	Met
GS 1	Grievance system	8/0/0	Met
GS 2	Filing requirements: procedures	2/0/0	Met
GS 3	Notice of action	1/0/0	Met
GS 4	Content of notice action	5/1/0	Partially Met
GS 5	Record-keeping and reporting requirements	1/0/0	Met
GS 6	Handling of grievances and appeals: special requirements for appeals	6/0/0	Met
GS 7	Resolution and notification: grievances and appeals—standard resolution	2/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
GS 8	Resolution and notification: grievances and appeals—expedited appeals	4/0/0	Met
GS 9	Resolution and notification	2/1/0	Partially Met
GS 10	Requirements for state fair hearings	2/1/0	Partially Met
GS 11	Effectuation of reversed appeal resolutions	2/0/0	Met

Scoring for the individual elements can be found in Appendix I-A1, including recommendations for elements that did not achieve full compliance. Detailed findings for each of the 47 review standards by element can be found in Appendix I-A2.

Conclusions and Recommendations

Conclusions

In the overall results, CareNet achieved a score of fully met for 42 of the 47 standards evaluated as part of the review of the Enrollee Rights, Quality Assessment, and Grievances Systems. A review determination of partially met was achieved for the remaining five (5) standards. None of the 47 standards received a review determination of "Not Met" for the CY 2004 review.

The specific results of the seven (7) Enrollee Rights standard indicate that five (5) achieved a score of fully met and one (1) received a score of partially met. All of the 29 Quality Assessment and Performance Improvement standards were fully met. Of the 11 Grievance System standards, eight (8) were fully met and three (3) were partially met. None of the individual standards received a rating of not met.

Recommendations

The recommendations below are a summary of those listed in the Recommendations At-A-Glance Matrix (Appendix IA1). Implementation of these recommendations will facilitate a review determination of full compliance in the next EQRO review as well as serve to strengthen the MCO's program.

- CareNet must revise the Communication Barrier Interventions for CareNet policy to include how it will communicate the availability of written MCO enrollee materials information in alternative formats for enrollees and potential enrollees who are visually impaired or who have limited reading proficiency.
- CareNet must develop a policy on communicating the availability of a second opinion to enrollees. It is noted that excerpts provided from the draft Member Handbook, revised July 2005, provided evidence of communication of procedures for requesting a no-cost second opinion.

- The Notice of Action letters must include circumstances under which the enrollee has the right to request that benefits continue pending the appeal resolution and the circumstances under which the enrollee may be required to pay the cost of services.
- CareNet must revise the Fast (Expedited) Appeal Process policy to include the requirement for the date of the appeal decision to be included in the written notification to the enrollee.
- CareNet must revise its policies (UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process) to include the time frame for delivery of the monthly appeals report to DMAS and the required report content.

Appendix I-A1
Recommendations At-A-Glance

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services					
1.1	Enrollee rights and responsibilities.	X			
1.2	Out of area coverage.	X			
1.3	Restrictions on enrollee's freedom of choice among network providers (431.51).	X			
1.4	Referrals to specialty care (422.113c).	X			
1.5	Enrollee notification – termination/change in benefits, services, or service delivery site.	X			
1.6	Procedures that instruct how to contact enrollee services and a description of the department and its functions.	X			
1.7	Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).	X			
1.8	List of non-English speaking languages spoken by which contracted provider.	X			
1.9	Provider-enrollee communications.	X			
1.10	Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.	X			
1.11	Enrollment/ Disenrollment.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):					
2.1	Enrollee rights and responsibilities.				Exempt for the CY 2004 review
2.2	Enrollee identification cards – descriptions, how and when to use cards.	X			
2.3	All Benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.	X			
2.4	Procedures for obtaining out-of-area coverage.	X			
2.5	Procedures for restrictions on enrollee's freedom of choice among network providers.	X			
2.6	The MCO's policy on referrals for specialty care.	X			
2.7	Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.				Exempt for the CY 2004 review
2.8	Procedures on how to contact enrollee services and a description of the functions of enrollee services.	X			
2.9	Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
2.10	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area; include identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	X			
2.11	Procedures for provider-enrollee communications.	X			
2.12	Procedures for providing information on physician incentive plans for those enrollees who request it.				Exempt for the CY 2004 review
2.13	Process for enrollment and disenrollment from MCO.	X			
ER3. Information and Language requirements (438.10)					
3.1	MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) of its particular service area.	X			
3.2	Enrollee information is written in prose that is readable and easily understood.	X			
3.3	State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
3.4	Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program),notices advising LEP persons of the availability of free language assistance."	X			
3.5	MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	X			
3.6	MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.	X			
3.7	MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
3.8	MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.		X		CareNet must revise the Communication Barrier Interventions for CareNet policy to include how it will communicate the availability of written MCO enrollee materials information in alternative formats for enrollees and potential enrollees who are visually impaired or who have limited reading proficiency.
ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).					
4.1	MCO has a confidentiality agreement in place with providers who have access to PHI.	X			
4.2	The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).	X			
4.3	The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.	X			
ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)					
5.1	MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	X			
5.2	MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
5.3	MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	**X**			
5.4	MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation (Medical HelpLine Access).	**X**			
5.5	MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.	**X**			
ER6. Advanced Directives					
6.1	The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.				Exempt for the Cy 2004 review
6.2	MCO has requirements to allow enrollees to participate in treatment decisions/options.	**X**			
6.3	Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	**X**			
6.4	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.5	MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.		X		CareNet must develop a policy on communicating the availability of a second opinion to enrollees. It is noted that excerpts provided from the draft Member Handbook, revised July 2005, provided evidence of communication of procedures for requesting a no-cost second opinion.
ER7. Rehabilitation Act, ADA					
7.1	MCO is in compliance with Federal and State laws regarding enrollee confidentiality.	X			
7.2	MCO has provided the enrollee with a description of their confidentiality policies.	X			
7.3	MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.				Exempt for the CY 2004 review

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
QA1. 438.206 Availability of services (b)					
1.1	MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:	**X**			
1.2	MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	**X**			
QA2. 438.206 Availability of services (b)(2)					
2.1	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	**X**			
QA3. 438.206 Availability of services (b)(3)					
3.1	MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	**X**			
QA4. 438.206 Availability of services (b)(4)					
4.1	MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	**X**			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA5. 438.206(c) (2) Cultural considerations.					
5.1	The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.	X			
QA6. 438.208 Coordination and continuity of care.					
6.1	MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	X			
QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs					
7.1	The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	X			
QA8. 438.208(c) (4) Direct Access to specialists					
8.1	The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	X			
8.2	Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans					
9.1	The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.	X			
QA10. 438.208(e) Primary Care and Coordination Program					
10.1	MCO coordinates services furnished to enrollee with those of other MCOs, PHPs, or PAHPs to prevent duplication.	X			
10.2	Coordination of care across settings or transitions in care.	X			
10.3	MCO has policies and procedures to protect enrollee privacy while coordinating care.	X			
QA11. 438.210 (b) Coverage and Authorization of Services - Processing of requests					
11.1	The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	X			
11.2	MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.	X			
11.3	The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.	X			
11.4	The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
11.5	If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	X			
11.6	Subcontractor's UM plan is submitted annually and upon revision.	X			
11.7	The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			
11.8	MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	X			
11.9	MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	X			
QA12. 438.210 (c) Coverage and authorization of services - Notice of adverse action.					
12.1	MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions.					
13.1	MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	X			
QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions					
14.1	The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.	X			
14.2	The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.	X			
QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements.					
15.1	The MCO has written policies and procedures for selection and retention of providers.	X			
15.2	MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
15.3	MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	X			
QA16. 438.214 (c) Provider selection -Nondiscrimination.					
16.1	MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	X			
QA17. 438.12 (a, b) Provider discrimination prohibited					
17.1	For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	X			
QA18. 438.214 (d) Provider Selection – Excluded Providers					
18.1	MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements.	X			
QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO					
19.1	MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA20. 438.56 (c) Provider Enrollment and Disenrollment – requested by enrollee					
20.1	MCO has policies and procedures in place for enrollees to request disenrollment.	X			
20.2	MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	X			
QA21. 438.228 Grievance systems					
21.1	MCO has a process for tracking requests for covered services that were denied.	X			
21.2	MCO has process for fair hearing notification.	X			
21.3	MCO has process for provider notification.	X			
21.4	MCO has process for enrollee notification and adheres to state timeframes.	X			
QA22. 438.230 Subcontractual relationships and delegation.					
22.1	MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	X			
22.2	MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor; and	X			
22.3	MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
22.4	MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	X			
QA23. 438.236 (a, b) Practice guidelines.					
23.1	The MCO has adopted practice guidelines that meet current quality standards and the following:				
a)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	X			
b)	Consider the needs of enrollees.	X			
c)	Are adopted in consultation with contracting health care professionals; and	X			
d)	Are reviewed and updated periodically, as appropriate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA24. 438.236 (c) Dissemination of Practice Guidelines					
24.1	The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X			
QA25. 438.236 (d) Application of Practice Guidelines					
25.1	MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	X			
QA26. 438.240 Quality assessment and performance improvement program					
26.1	MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.	X			
26.2	MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	X			
26.3	The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	X			
QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services					
27.1	MCO's QAPI program has mechanisms to detect both underutilization and over utilization of the MCO services.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs					
28.1	MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	X			
QA29. 438.242 Health/Management Information systems.					
29.1	The MCO has information systems capable of furnishing timely, accurate, and complete information about the MCO program.	X			
29.2	The MCO information system is capable of: a. Accepting and processing enrollment. b. Reconciling reports of MCO enrollment/ Eligibility. c. Accepting and Processing provider claims and encounter data. d. Tracking provider network composition, access to services, grievances and appeals. e. Performing QI activities.	X			
29.3	Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
29.4	MCO ensures that data submitted by providers is accurate by: a. Verifying the accuracy and timeliness of reported data. b. Screening the data for completeness, logic, and consistency. c. Collecting the service information in standard formats for DMAS. d. Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to the MCO.	X			
29.5	MCO uses encryption processes to send PHI over the internet.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS1. 438.402 (a, b) Grievance System					
1.1	MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	X			
1.2	The definitions for grievances and appeals are consistent with those established by the state 7/03.	X			
1.3	Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the MCO program separately from other programs.	X			
1.4	Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.	X			
1.5	Policies and procedures describe the documentation process and actions taken.	X			
1.6	Policies and procedures describe the aggregation and analysis of the data and use in QI.	X			
1.7	The procedures and any changes to the policies must be submitted to the DMAS annually.	X			
1.8	MCO provides information about grievance and appeals system to all providers and subcontractors.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS2. 438.402 (3) Filing Requirements- Procedures					
2.1	The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	X			
2.2	The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	X			
GS3. 438.404 Notice of Action					
3.1	Notice of action is written according to language and format requirements set forth in GS 438.10 Information Requirements.	X			
S4. 438.404 (b) Content of Notice Action **Content of NOA explains all of the following:**					
4.1	The action taken and reasons for the action.	X			
4.2	The enrollee's right to file an appeal with MCO.	X			
4.3	The enrollee's right to request a State fair hearing.	X			
4.4	The procedures for exercising appeal rights.	X			
4.5	The circumstances under which expedited resolution is available and how to request an expedited resolution.	X			
4.6	The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.		X		The Notice of Action letters must include circumstances under which the enrollee has the right to request that benefits continue pending the appeal resolution and the circumstances under which the enrollee may be required to pay the cost of services.

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS5. 438.416 Record Keeping and reporting requirements					
5.1	The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	X			
GS6. 438.406 Handling of grievances and appeals – special requirements for appeals					
6.1	MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating the enrollee's condition or disease.	X			
6.2	MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	X			
6.3	MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.	X			
6.4	MCO informs enrollee of limited time available for cases of expedited resolution.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
6.5	MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	X			
6.6	MCO continues benefits while appeal or state fair hearing is pending.	X			
GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution					
7.1	MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires- not exceeding 30 days from initial date of receipt of the appeal.	X			
7.2	In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	X			
GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals					
8.1	MCO has an expedited appeal process.	X			
8.2	The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	X			
8.3	MCO has a process for extension, and for notifying enrollee of reason for delay.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
8.4	MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.	X			
GS9. 438.408 (b -d) Resolution and notification					
9.1	MCO decisions on expedited appeals are in writing and include decision and date of decision.		X		CareNet must revise the Fast (Expedited) Appeal Process policy to include the requirement for the date of the appeal decision to be included in the written notification to the enrollee.
9.2	For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	X			
9.3	MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.	X			
GS10. 438.408 (c) Requirements for State Fair Hearings					
10.1	MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
10.2	MCO provides state with a summary describing basis for denial and for appeal.		X		CareNet must revise its policies (UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process) to include the time frame for delivery of the monthly appeals report to DMAS and the required report content.
10.3	MCO faxes appeal summaries to state in expedited appeal cases.	X			
GS11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions					
11.1	The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or the state fair hearing department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	X			
11.2	MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.	X			

Subpart C Regulations: Enrollee Rights and Protections

ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services

Element 1.1 - Enrollee rights and responsibilities.
This element is met.

The Southern Health Policies and Procedures: CareNet Member Rights and Responsibilities, revised May 12, 2005, lists all of the enrollee rights outlined in the 2003-2004 Medallion II Contract Modification including the four rights identified as missing in the 2003 review.

Element 1.2 - Out of area coverage.
This element is previously met - not reviewed.

Element 1.3 - Restrictions on enrollee's freedom of choice among network providers (431.51).
This element is met.

The Southern Health Policies and Procedures: Family Planning provides for enrollee freedom of choice in selecting a family planning provider for family planning services and supplies regardless of their participation status.

Element 1.4 - Referrals to specialty care (422.113c).
This element is previously met - not reviewed.

Element 1.5 - Enrollee notification – termination/change in benefits, services, or service delivery site.
This element is met.

The Southern Health Policies and Procedures: Notification to Members of Benefit Changes, effective April 2005, requires enrollees be notified through an amendment to the current Member Handbook and Evidence of Coverage (EOC) or a revised Member Handbook and EOC no later than 60 days from the effective date of the change in benefits or services.

The Southern Health Policies and Procedures: Provider Status Change Notification to Members, revised April 2005, includes procedures for notifying enrollees of a status change concerning the enrollee's participating provider including termination, joining another practice, or opening a new practice. The policy addresses not only primary care providers but also specialty providers, free standing facilities, and hospitals.

Recommendation:
It is recommended that CareNet revise its policy to notify enrollees of a benefit change at least 30 days prior to the effective date, if possible, but no later than 30 days from the effective date of the change to be consistent with industry standards.

Element 1.6 - Procedures that instruct how to contact enrollee services and a description of department and its functions.
This element is met.

The Southern Health Policies and Procedures: CareNet Customer Service Organization, effective January 2005, describes the functions of the Customer Service Department, hours of operation, and toll free telephone and TTY/TDD lines for enrollee and provider questions.

Recommendation:
This policy could be strengthened by including how CareNet will advise enrollees and providers of the availability of the Customer Service Department, its functions, and contact information through vehicles such as the Member Handbook and the provider manual.

Element 1.7 - Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).
This element is met.

In the 2003 review CareNet's complaint/grievance and appeal procedures were found to address all the requirements of the regulation with the exception of the State Fair Hearing process. Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all include procedures for educating enrollees on their right to file an Adverse Action directly to the Department of Medical Assistance Services (DMAS), filing time frames, and CareNet's role in the process. The draft July 2005 version of the Member Handbook also includes information on the state fair hearing process and procedures for requesting such a hearing.

Element 1.8 - List of non-English languages spoken by contracted providers.
This element is previously met - not reviewed.

Element 1.9 - Provider-enrollee communications.
This element is met.

Southern Health Policies and Procedures: Protection on Enrollee-Provider Communication, effective April 2005, states that CareNet must not prohibit or restrict a health care professional from advising an

enrollee about his or her health status, medical care, or treatment, regardless of whether benefits for such are provided under the contract, if the provider is acting within the lawful scope of practice.

Element 1.10 - Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.
This element is met.

The Southern Health Policies and Procedures: Notification to Members of Plan Insolvency, effective April 2005, includes procedures for notifying CareNet enrollees that they are not liable for the payment of claims for covered services incurred while enrolled in CareNet should Southern Health Services receive an insolvency order.

Element 1.11 - Process for enrollment and disenrollment from MCO.
This element is met.

CareNet was found to have policies for processing enrollment in the 2003 review; however, there was no evidence of policies or procedures for processing disenrollment. In response to the 2003 findings CareNet has submitted the Southern Health Policies and Procedures: Processing Disenrollment for CareNet Members. This policy outlines procedures and time frames for voluntary disenrollment as well as involuntary disenrollment relating to commission of Medicaid fraud or termination of the contract between CareNet and DMAS. Compliance with this element is therefore determined to be met.

ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):

Element 2.1 - Enrollee rights and responsibilities.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting CareNet in meeting this element in the next review.

As evidence of compliance with this element CareNet submitted an excerpt from the draft Member Handbook, revised July 2005, entitled Your Rights. This section lists all of the enrollee rights outlined in

the 2003-2004 Medallion II Contract Modification including the four missing rights identified in the 2003 review. This listing satisfies the requirements of this element.

Element 2.2 - Enrollee identification cards – descriptions and how and when to use cards.
This element is previously met - not reviewed.

Element 2.3 - All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.
This element is previously met - not reviewed.

Element 2.4 - Procedures for obtaining out-of-area coverage.
This element is previously met - not reviewed.

Element 2.5 - Procedures for restrictions on enrollee's freedom of choice among network providers.
This element is previously met - not reviewed.

Element 2.6 - The MCO's policy on referrals for specialty care.
This element is previously met - not reviewed.

Element 2.7 - Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting CareNet in meeting this element in the next review.

A July 2005 draft of the Member Handbook includes a section on Change in CareNet Benefits or Services advising enrollees that they will be notified in writing or through an update to the Member Handbook of any changes. Additionally, in the Your Rights section enrollees are advised that they will be notified at least 14 days before there are any program or site changes that affect them. This proposed revision satisfies the requirement of this element.

Element 2.8 - Procedures on how to contact enrollee services and a description of the functions of enrollee services.
This element is previously met - not reviewed.

Element 2.9 - Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is previously met - not reviewed.

Element 2.10 - Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
This element is previously met - not reviewed.

Element 2.11 - Procedures for provider-enrollee communications.
This element is previously met - not reviewed.

Element 2.12 - Procedures for providing information on physician incentive plans for those enrollees.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting CareNet in meeting this element in the next review.

The draft Member Handbook, revised July 2005 includes in the Your Rights section the right to ask for a description of all types of payment arrangements that Southern Health uses to pay providers for health care services for CareNet members. These payment arrangements may include withholds, bonus payments, capitation, and fee-for-service discounts. Southern Health must respond to requests in 10 working days. This proposed revision satisfies the requirement of this element.

Recommendation:
It is recommended that CareNet include specific contact information, such as department name and telephone number, to assist enrollees with requesting information on physician incentive plans.

Element 2.13 - Process for enrollment and disenrollment from MCO.
This element is previously met - not reviewed.

ER3. Information and Language requirements (438.10)

Element 3.1 - MCO written enrollee information is available in the prevalent, non-English languages spoken in its particular service area (see DMAS contract).
This element is previously met - not reviewed.

Element 3.2 - Enrollee information is written in prose that is readable and easily understood.
This element is previously met - not reviewed

Element 3.3 - State requires Flesch-Kincaid readability of 40 or higher (at or below 12th grade level).
This element is previously met - not reviewed.

Element 3.4 - Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents include: "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program), ...notices advising people with limited English proficiency of the availability of free language assistance."
This element is previously met - not reviewed.

Element 3.5 - MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is met.

The Southern Health Policies and Procedures: Communication Barrier Interventions for CareNet, revised December 2004, includes procedures for providing written materials in alternative formats. For enrollees with limited English proficiency interpreter services are available and plan documents are to be translated into any prevalent non-English language when a 5% membership threshold is met. For enrollees who are visually impaired CareNet will produce the Member Handbook in large print, in Braille, or on audiotape based upon an enrollee request. In the past CareNet has produced documents in alternative formats that have never been used. Since this is a costly process they have changed their policy to produce these documents upon request only. Information is provided in the draft Member Handbook, revised July 2005, informing enrollees of the availability of plan documents in an alternative format including contact numbers for assistance.

Element 3.6 - MCO has policies and procedures in place to make interpretation services available and free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those the state identifies as prevalent.
This element is previously met - not reviewed.

Element 3.7 - MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.
This element is previously met - not reviewed.

Element 3.8 - MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
This element is partially met.

The Southern Health Policies and Procedures: Communication Barrier Interventions for CareNet, revised December 2004, requires each enrollment packet to include a multilingual notice that describes interpreter services that are available and provides instructions explaining how enrollees can access those interpreter services. It does not address how CareNet will communicate to enrollees about the availability of alternative formats for enrollees who are visually impaired or have limited reading proficiency. The draft July 2005 version of the Member Handbook does include information about the availability of interpreter services for non-English speaking enrollees as well as the availability of the Member Handbook in a larger print or a recorded or audio taped version for members who are visually impaired.

Recommendation:
In order to receive a finding of met in the next EQRO review CareNet needs to revise the above policy to include how it will communicate the availability of written MCO enrollee materials information in an alternative formats for enrollees and potential enrollees who are visually impaired or have limited reading proficiency.

ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Element 4.1 - MCO has a confidentiality agreement in place with providers who have access to PHI.
This element is previously met - not reviewed.

Element 4.2 - The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).
This element is previously met - not reviewed.

Element 4.3 - The Contractor shall make an individual's PHI available to the Department within 30 days of an individual's request for such information as notified and in the format requested by the Department.
This element is met.

The Coventry Health Care Policies and Procedures: Access and Amendment to Designated Record Set, revised April 2005, requires CareNet to make available to DMAS an enrollee's Protected Health Information (PHI) within 30 days of an enrollee's request for such information. The policy includes procedures for providing requested PHI in a written document or a report electronically, if requested, such as on diskette and in a specific file format, subject to review by the Privacy Office.

ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)

Element 5.1 - MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.
This element is met.

In the 2003 review CareNet provided evidence of policies/procedures that address emergency care, however, there was no reference to post stabilization services. In response to these findings CareNet provided the Southern Health Policies and Procedures: Emergency Services, revised March 2005. This policy includes the definition of post stabilization services and the waiver of pre-certification requirements for this service. The draft Member Handbook with a revised date of July 2005 includes a definition of post stabilization services in the section Post Stabilization Care. It also identifies coverage requirements including pre-approval by Southern Health, which is in direct conflict with the policy described above.

Recommendations
It is recommended that CareNet revise the Member Handbook to eliminate the requirement for pre-approval of post stabilization care to be consistent with this policy.

Element 5.2 - MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.
This element is previously met - not reviewed.

Element 5.3 - MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
This element is previously met - not reviewed.

Element 5.4 - MCO has provided enrollees with a description of how to obtain emergency transportation and other medical necessary transportation (Medical HelpLine Access).
This element is previously met - not reviewed.

Element 5.5 - MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.
This element is met.

The Spring 2005 edition of the Provider Directory asterisks participating hospitals that provide emergency room services and post stabilization care. The draft Member Handbook, revised July 2005, advises enrollees of the availability of this information in the Provider Directory or by calling the CareNet Customer Service number provided.

ER6. Advanced Directives

Element 6.1 - The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting CareNet in meeting this element in the next review.

The July 2005 draft version of the Member Handbook includes a section on Advance Directives that describes the two types of advance directives outlined in Virginia state law, a living will and medical power of attorney. The enrollee is advised that their doctor or other health care provider will write down their wishes or make a copy of their written wishes if they already have them. This information will be

included in their medical records. Additionally, enrollees are instructed to advise their provider if they have certain moral and/or religious beliefs that would prevent them from considering advance directives. These objections are to be documented in their medical record. This proposed revision satisfies the requirement of this element.

Element 6.2 - MCO has requirements to allow enrollees to participate in treatment decisions/options.
This element is previously met - not reviewed.

Element 6.3 - Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.
This element is previously met - not reviewed.

Element 6.4 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

Element 6.5 - MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.
This element is partially met.

The Southern Health Policies and Procedures: CareNet Members Requesting a Second Opinion, effective January 2005, provides for a no cost second opinion within the network or outside the network if necessary. There were no procedures for communicating the availability of a second opinion to enrollees, however, excerpts provided from the draft Member Handbook, revised July 2005, evidenced communication of procedures for requesting a no cost second opinion.

Recommendation:
In order to receive a finding of met in the next EQRO review it is recommended that CareNet specifically include language in the above policy that identifies how enrollees will be informed about the availability of a no cost second opinion, such as through the Member Handbook.

ER7. Rehabilitation Act, ADA

Element 7.1 - MCO complies with Federal and State laws regarding enrollee confidentiality.
This element is met.

The Coventry Health Care Policies and Procedures: Privacy Compliance Program, revised March 2004, outlines comprehensive procedures for monitoring compliance with federal and state laws regarding enrollee confidentiality. Compliance is monitored through both an annual internal audit and a biannual external review of Coventry's Privacy Compliance Program. Based on any adverse findings arising from the internal audit, the Privacy Office is to develop a corrective action plan to address any deficiencies identified through the auditing and monitoring process. The audit report and corrective action plan are to be reviewed with the Chief Privacy Officer. All documentation of the audit review findings, outcomes, and corrective action are to be retained for a minimum of six years.

Once an external audit is completed the Privacy Office is to meet with the Chief Privacy Officer to review the audit findings. The Chief Privacy Officer is to provide a report of audit findings, as appropriate, to the Board of Directors. If the audit findings show non-compliance with this policy, the Privacy Office, with the assistance of the Business Unit Privacy Leaders, must develop a procedure by which such conduct that was found to be non-compliant is corrected. In addition, the Privacy Office must ensure that the individuals responsible for such non-compliance are sanctioned appropriately in accordance with this policy.

Review of the Privacy Compliance Program Business Unit Privacy Leader Annual Tasks document supported compliance with the annual internal audit requirement noted in the above policy. A signed certification of completion dated March 31, 2004 included the areas and departments involved in the audit process.

Element 7.2 - MCO has provided the enrollee with a description of their confidentiality policies.
This element is previously met - not reviewed.

Element 7.3 - MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting CareNet in meeting this element in the next review.

The July 2005 draft of the Member Handbook in the section on Confidentiality and Requirements for Your Medical Record describes procedures for requesting medical or personal records from CareNet or

the enrollee's CareNet provider and includes time frames for release. This proposed change satisfies the requirement of this element.

Subpart D Regulations: Quality Assessment and Performance Improvement

QA1. 438.206 Availability of services (b).

Element 1.1 - MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
This element is previously met - not reviewed.

Element 1.2 - MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.
This element is previously met - not reviewed.

QA2. 438.206 Availability of services (b)(2).

Element 2.1 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

QA3. 438.206 Availability of services (b)(3).

Element 3.1 - MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is met.

The Southern Health Policies and Procedures: CareNet Members Requesting a Second Opinion, with an effective date of January 2005, provides for CareNet enrollees to obtain a second medical opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to the enrollee.

QA4. 438.206 Availability of services (b)(4)

Element 4.1 - MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.
This element is met.

The Southern Health Policies and Procedures: Out of Network Coverage, effective April 2005, outlines procedures for coverage of out of network services when either the enrollee is outside of the service area or when a necessary service cannot be provided in network.

QA5. 438.206(c)(2) Cultural considerations.

Element 5.1 - The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.
This element is previously met - not reviewed.

QA6. 438.208 Coordination and continuity of care.

Element 6.1 - MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.
This element is previously met - not reviewed.

QA7. 438.208(c) 1-3 Additional services for enrollees with special health care needs.

Element 7.1 - The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.
This element is previously met - not reviewed.

QA8. 438.208(c) (4) Direct access to specialists.

Element 8.1 - The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.
This element is met.

The Southern Health Services Policy and Procedure: Preauthorization, revised April 2005, provides for enrollee direct access to participating specialists (i.e. no referral is required from the enrollee's PCP).

Element 8.2 - Referral guidelines that demonstrate the conditions under which PCPs arrange for referrals to specialty care networks.
This element is previously met - not reviewed.

QA9. 438.208 (d) (2) (ii – iii) Referrals and treatment plans.

Element 9.1 - The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is previously met - not reviewed.

QA10. 438.208(e) Primary care and coordination program.

Element 10.1 - MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.
This element is previously met - not reviewed.

Element 10.2 - Coordination of care across settings or transitions in care.
This element is previously met - not reviewed.

Element 10.3 - MCO has policies and procedures to protect enrollee privacy while coordinating care.
This element is previously met - not reviewed.

QA11. 438.210 (b) Coverage and authorization of services - processing of requests.

Element 11.1 - The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.
This element is previously met - not reviewed.

Element 11.2 - MCO has policies/procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventive services and basic prenatal care.
This element is previously met - not reviewed.

Element 11.3 - The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.
This element is previously met - not reviewed.

Element 11.4 - The MCO has policies/procedures in place for staff to consult with requesting providers when appropriate.
This element is previously met - not reviewed.

Element 11.5 - If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.
This element is previously met - not reviewed.

Element 11.6 - Subcontractor's utilization management plan is submitted annually and upon revision.
This element is previously met - not reviewed.

Element 11.7 - The MCO has policies/procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
This element is previously met - not reviewed.

Element 11.8 - MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.
This element is previously met - not reviewed.

Element 11.9 - MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.
This element is previously met - not reviewed.

QA12. 438.210 (c) Coverage and authorization of services - notice of adverse action.

Element 12.1 MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.
This element is previously met - not reviewed.

QA13. 438.210 (d) (1) Timeframe for decisions – standard authorization decisions.

Element 13.1 - MCO provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.
This element is met.

The Southern Health Policies and Procedures: UM Decision Making & Time Frame Standards, revised April 2005, allows CareNet to extend the 14 calendar days turnaround time frame by up to fourteen (14) additional calendar days if the enrollee or provider requests an extension or CareNet justifies to the DMAS a need for additional information and how the extension is in the enrollee's interest.

QA14. 438.210 (d) (2) Timeframe for decisions – expedited authorization decisions.

Element 14.1 - The MCO has policies/procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service.
This element is previously met - not reviewed.

Element 14.2 - The MCO has policies/procedures relating to the extension time frames for expedited authorizations allowed under the state contract.
This element is met.

The Southern Health Policies and Procedures: UM Decision Making & Time Frame Standards, revised April 2005, allows CareNet to extend the three working days turnaround time frame by up to fourteen (14) calendar days if the enrollee requests an extension or CareNet justifies to the DMAS a need for additional information and how the extension is in the enrollee's interest.

QA15. 438.214 (b) Provider selection - credentialing and recredentialing requirements.

Element 15.1 - The MCO has written policies/procedures for selection and retention of providers using 2003 NCQA guidelines.
This element is previously met - not reviewed.

Element 15.2 - MCO recredentialing process takes into consideration the performance indicators obtained through quality improvement projects (QIPs), utilization management program, grievances and appeals, and enrollee satisfaction surveys.
This element is previously met - not reviewed.

Element 15.3 - MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.
This element is previously met - not reviewed.

QA16. 438.214 (c) Provider selection -nondiscrimination.

Element 16.1 - MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
This element is previously met - not reviewed.

QA17. 438.12 (a, b) Provider discrimination prohibited.

Element 17.1 - For those individual or group providers who are declined, the MCO provides written notice with reason for decision.
This element is previously met - not reviewed.

QA18. 438.214 (d) Provider Selection – excluded providers.

Element 18.1 - MCO has policies/procedures and adheres to ineligible provider or administrative entities requirements set forth in K. Provider Relations.
This element is previously met - not reviewed.

QA19. 438.56 (b) Provider enrollment and disenrollment – requested by MCO.

Element 19.1 - MCO has policies/procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.
This element is previously met - not reviewed.

QA20. 438.56 (c) Provider enrollment and disenrollment – requested by enrollee.

Element 20.1 - MCO has policies/procedures in place for enrollees to request disenrollment.
This element is met.

The Southern Health Policies and Procedures: Processing Disenrollment for CareNet Members, revised May 2005, outlines procedures for enrollees requesting disenrollment by contacting the DMAS Managed Care Help Line. Time frames are specified for disenrolling without cause.

Element 20.2 - MCO has policies/procedures and adheres to time frames established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).
This element is previously met - not reviewed.

QA21. 438.228 Grievance systems.

Element 21.1 - MCO has a process for tracking requests for covered services that were denied.
This element is previously met - not reviewed.

Element 21.2 - MCO has process for fair hearing notification.
This element is previously met - not reviewed.

Element 21.3 - MCO has process for provider notification.
This element is previously met - not reviewed.

Element 21.4 - MCO has process for enrollee notification and adheres to state time frames.
This element is previously met - not reviewed.

QA22. 438.230 Subcontractual relationships and delegation.

Element 22.1 - MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.
This element is previously met - not reviewed.

Element 22.2 - MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.
This element is previously met - not reviewed.

Element 22.3 - MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
This element is previously met - not reviewed.

Element 22.4 - MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.
This element is previously met - not reviewed.

QA23. 438.236 (a, b) Practice guidelines.

Element 23.1 - The MCO has adopted practice guidelines that meet current NCQA standards and the following:

a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
This component is previously met - not reviewed.

b) Consider the needs of the enrollees.
This component is previously met - not reviewed.

c) Are adopted in consultation with contracting health care professionals.
This component is previously met - not reviewed.

d) Are reviewed and updated periodically, as appropriate.
This component is previously met - not reviewed.

QA24. 438.236 (c) Dissemination of practice guidelines.

Element 24.1 - The MCO has policies/procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is previously met - not reviewed.

QA25. 438.236 (d) Application of practice guidelines.

Element 25.1 - MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.
This element is previously met - not reviewed.

QA26. 438.240 Quality assessment and performance improvement program.

Element 26.1 - MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.
This element is previously met - not reviewed.

Element 26.2 - MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
This element is previously met - not reviewed.

Element 26.3 - The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
This element is previously met - not reviewed.

QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.

Element 27.1 - MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.
This element is previously met - not reviewed.

QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs.

Element 28.1 - MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.
This element is previously met - not reviewed.

QA29. 438.242 Health/management information systems.

Element 29.1 - The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.
This element is previously met - not reviewed.

Element 29.2 - The MCO information system is capable meeting requirements.
This element is previously met - not reviewed.

Element 29.3 - Furnishing DMAS with timely, accurate and complete clinical and administrative information.
This element is previously met - not reviewed.

Element 29.4 - MCO ensures that data submitted by providers are accurate by meeting requirements.
This element is previously met - not reviewed.

Element 29.5 - MCO uses encryption processes to send PHI over the Internet
This element is met.

The Southern Health Policies and Procedures: Secure E-Mail Process, effective April 2005, outlines procedures for use of the Zix Secure Messaging System to send PHI and other sensitive information securely via email to external entities.

Subpart F Regulations: Grievance Systems

GS1. 438.402 (a, b) Grievance system.

Element 1.1 - MCO has written policies and procedures that describe the grievance and appeals process and how it operates.
This element is previously met - not reviewed.

Element 1.2 - The definitions for grievances and appeals are consistent with those established by the state in July 2003.
This element is previously met - not reviewed.

Element 1.3 - Policies/procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.
This element is previously met - not reviewed.

Element 1.4 - Policies/procedures describe how MCO responds to grievances and appeals in a timely manner.
This element is previously met - not reviewed.

Element 1.5 - Policies/procedures describe the documentation process and actions taken.
This element is previously met - not reviewed.

Element 1.6 - Policies/procedures describe the aggregation and analysis of the data and use in quality improvement.
This element is met.

Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all include procedures for aggregating, analyzing, and reporting appeal data on a quarterly basis to the Administrative Quality Improvement Committee (AQIC). The Appeals Coordinator (AC) is responsible for preparing the quarterly AQIC report highlighting the overturn rate, comparison to the Corporate threshold of 25%, and compliance with established time frames for completion. If any issues are identified, the AC is to perform an analysis in an effort to bring closure to the problem and reduce or prevent future appeals, if possible.

All AQIC reports are then presented to the Executive Quality Improvement Committee (EQIC) quarterly. In addition, the AC leads a monthly meeting called the Root Cause Analysis meeting. The purpose of this meeting is to identify areas/issues for all Southern Health appeals and reconsiderations where there are consistent overturns and to develop procedures to reduce or prevent future appeals.

Element 1.7 - The procedures and any changes to the policies/procedures must be submitted to the DMAS annually.
This element is previously met - not reviewed.

Element 1.8 - MCO provides information about grievance and appeals system to all providers and subcontractors.
This element is previously met - not reviewed.

GS2. 438.402 (3) Filing requirements- procedures.

Element 2.1 - The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.
This element is previously met - not reviewed.

Element 2.2 - The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
This element is previously met - not reviewed.

GS3. 438.404 Notice of action.

Element 3.1 - Notice of action is written according to language and format requirements set forth in **GS.** 438.10 Information Requirements.
This element is previously met - not reviewed.

GS4. 438.404 (b) Content of notice of action.
Content of NOA explains all of the following:

Element 4.1 - The action taken and reasons for the action.
This element is previously met - not reviewed.

Element 4.2 - The enrollee's right to file an appeal with MCO.
This element is previously met - not reviewed.

Element 4.3 - The enrollee's right to request a state fair hearing.
This element is previously met - not reviewed.

Element 4.4 - The procedures for exercising appeal rights.
This element is previously met - not reviewed.

Element 4.5 - The circumstances under which expedited resolution is available and how to request an expedited resolution.
This element is previously met - not reviewed.

Element 4.6 - The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
This element is partially met.

The NOA letter does not contain the above required language relating to benefit continuation and liability for costs of those services. This language, however, is included in three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members. All include a section on Continuation of Benefits During Pendency of Appeal Process, which lists the criteria for benefit continuation while the enrollee's appeal, state fair hearing, or External Review process is pending. It also addresses CareNet's right to pursue recovery of the cost of services rendered to the enrollee while the appeal was pending if the final resolution of the appeal is adverse to the enrollee and the original adverse action is upheld. The July 2005 draft of the Member Handbook also includes a section, which lists the criteria for benefit continuation and CareNet's right of recovery if the initial appeal decision is upheld.

Recommendation:
In order to receive a finding of met in the next review there must be evidence of the above required language in all NOA letters.

GS5. 438.416 Record keeping and reporting requirements.

Element 5.1 - The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.
This element is previously met - not reviewed.

GS6. 438.406 Handling of grievances and appeals – special requirements for appeals.

Element 6.1 - MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.
This element is met.

Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all require that individuals who are responsible for decision making relating to appeals have had no involvement in any previous reviews and are not the subordinate of an individual who made the prior adverse action being appealed. Additionally, for utilization management appeals the appeal must be reviewed by a peer of the treating provider who is licensed in that provider's same or similar specialty in Virginia or under comparable law in a state within the United States, is board certified or board eligible, and is not employed by or under the direction of the MCO.

Element 6.2 - MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.
This element is previously met - not reviewed.

Element 6.3 - MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.
This element is met.

Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all require CareNet to allow the enrollee or the enrollee's authorized representative to participate in the Appeals Committee and present the enrollee's case including presentations from any enrollee's representatives (e.g., physician, expert, etc.) in person, or via conference call or other appropriate technology. This is in addition to providing written information that supports the enrollee's appeal request.

Element 6.4 - MCO informs enrollee of limited time available for cases of expedited resolution.
This element is previously met - not reviewed.

Element 6.5 - MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.
This element is met.

Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all require CareNet to include in the notice of action the right of the enrollee or the enrollee's authorized representative to receive, upon request and free of charge, reasonable access and copies of all documents, records, and other information relevant to the appeal. Additionally, if the Appeal Committee decision is adverse the notice to the enrollee or the enrollee's authorized representative must include a statement that the enrollee is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the appeal.

Element 6.6 - MCO continues benefits while appeal or state fair hearing is pending.
This element is met.

Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all include a section on Continuation of Benefits During Pendency of Appeal Process which lists the criteria for benefit continuation while the enrollee's appeal or State fair hearing process is pending.

GS7. 438.408 Resolution and notification: grievances and appeals – standard resolution.

Element 7.1 - MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires-not exceeding 30 days from initial date of receipt of the appeal.
This element is previously met - not reviewed.

Element 7.2 - In cases of appeal decisions not being rendered within 30 days, MCO provides written notice to enrollee.
This element is previously met - not reviewed.

GS8. 438.408 Resolution and notification: grievances and appeals – expedited appeals.

Element 8.1 - MCO has an expedited appeal process.
This element is previously met - not reviewed.

Element 8.2 - The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three working days from the initial receipt of the appeal.
This element is previously met - not reviewed.

Element 8.3 - MCO has a process for extension, and for notifying enrollees of reason for delay.
This element is met.

The Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members, effective April 2005, allows CareNet to extend the time frame for resolving an expedited appeal by up to an additional 14 calendar days if the enrollee requests the extension or if CareNet provides evidence satisfactory to DMAS that a delay in rendering the decision is in the enrollee's interest. For any extension not requested by the enrollee, CareNet must provide written notice to the enrollee of the reason for the delay.

Element 8.4 - MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.
This element is met.

The Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members, effective April 2005, requires CareNet to make reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and to follow-up within two calendar days with a written notice of the adverse action.

GS9. 438.408 (b -d) Resolution and notification.

Element 9.1 - Decisions by the MCO to expedite appeals are in writing and include decision and date of decision.
This element is partially met.

As noted in GS 8.4 the Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members, effective April 2005, requires CareNet to provide the enrollee or the enrollee's

authorized representative with telephone and written notification of the Appeal Committee's decision as soon as possible, taking into account the medical exigencies of the case, but not later than forty-eight hours after receipt of the expedited appeal request. For cases involving prescriptions for the alleviation of cancer pain, the notification must be made within twenty-four hours from the receipt of the request. While this language satisfies the requirement for written notification of the expedited appeal decision it fails to include the date of the decision in the enrollee notification.

Recommendation:
In order to receive a finding of met in the next EQRO review CareNet must revise the above policy to include the requirement for date of appeal decision in the written notification to the enrollee.

Element 9.2 - For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a state fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.
This element is met.

As noted in GS 6.6 the Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members, effective April 2005, includes a section on Continuation of Benefits During Pendency of Appeal Process which lists the criteria for benefit continuation while the enrollee's appeal or State fair hearing process is pending. It also addresses CareNet's right to pursue recovery of the cost of services rendered to the enrollee while the appeal was pending if the final resolution of the appeal is adverse to the enrollee and the original adverse action is upheld. The July 2005 draft of the Member Handbook also includes a section, which lists the criteria for benefit continuation and CareNet's right of recovery if the initial appeal decision is upheld. Consistent with the 2003 EQRO review this new policy includes required language for informing the enrollee of their right and instructions for requesting a state fair hearing.

Element 9.3 - MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.
This element is met.

As noted in GS 8.4 the Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members, effective April 2005, requires CareNet to make reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and to follow-up within two calendar days with a written notice of the adverse action.

GS10. 438.408 (c) Requirements for state fair hearings.

Element 10.1 - MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.
This element is previously met - not reviewed.

Element 10.2 - MCO provides state with a summary describing basis for denial and for appeal.
This element is partially met.

Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all document procedures for generating the monthly CareNet appeals report for DMAS. The procedures conclude with the Appeal Coordinator completing the monthly CareNet Appeals report on Excel and forwarding it to the Operations Administrative Assistant. None of these policies address the fields to be reported or the responsible party and time frame for submitting the report to DMAS.

Recommendation:
In order to receive a finding of met in the next EQRO review the above policies need to be revised to include the time frame for delivery of the monthly appeals report to DMAS as well as required report content.

Element 10.3 - MCO faxes appeal summaries to state in expedited appeal cases.
This element is met.

The Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members, effective April 2005, includes under the section, State Fair Hearing for Medallion II Members, procedures for providing DMAS and the enrollee an appeal summary describing the basis for the denial. The appeal summary is to be faxed to DMAS and faxed or overnight mailed to the enrollee, as expeditiously as the enrollee's health condition requires, but no later than four business hours after DMAS informs CareNet of the fast (expedited) appeal.

GS11. 438.410 Expedited resolution of appeals, GS. 438.424 effectuation of reversed appeal resolutions.

Element 11.1 - The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or State Fair Hearing Department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.
This element is met.

Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all require CareNet to authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires if either CareNet's Appeals Committee or the state fair hearing' s decision is in favor of the enrollee.

Element 11.2 - MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.
This element is met.

Three new Southern Health Policies and Procedures, UM Appeal Process, Administrative Appeal Process, and Fast (Expedited) Appeal Process for CareNet Members, all require CareNet to provide reimbursement for disputed services that were continued during the MCO appeal or state fair hearing process if a decision is rendered in favor of the enrollee.

Summary of Documents Reviewed		
Element	**Document**	**Date**
ER 1	Southern Health Policies and Procedures: CareNet Member Rights and Responsibilities #CN-014	05/12/2005 revised
	Southern Health Policies and Procedures: Family Planning #CN-015	01/01/2005
	Southern Health Policies and Procedures: Notification to Members of Benefit Changes #CN- 016	04/04/2005 effective
	Southern Health Policies and Procedures: CareNet Customer Service #CN-022	01/01/2005 effective
	Southern Health Policies and Procedures: Notification to Members of Plan Insolvency #CN- 018	04/04/2005 effective
	Southern Health Policies and Procedures: Protection of Enrollee-Provider Communication #CN-017	04/04/2005 effective
	Southern Health Policies and Procedures: UM Appeal Process CareNet Members #CN-010	04/21/2005 effective
	Southern Health Policies and Procedures: Administrative Appeals Process CareNet Members #CN- 011	04/21/2005 effective
	Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members #CN- 012	04/21/2005 effective
	Southern Health Policies and Procedures: Processing Disenrollment for CareNet Members #CN- 019	04/04/2005 effective
	Member Handbook excerpt (draft)	07/2005 revised
	Southern Health Policies and Procedures: Provider Status Change Notification to Members #CN- 006	04/04/2005 revised
ER 2	Member Handbook excerpt (draft)	07/2005 revised
ER 3	Member Handbook excerpt (draft)	07/2005 revised
	Southern Health Policies and Procedures: Communication Barrier Interventions for CareNet #CN- 002	12/16/2004 revised
ER 4	Coventry Health Care Policies and Procedures: Access and Amendment to Designated Record Set #HPO- 006	04/07/2005 revised
ER 5	Provider Directory	Spring 2005
	Member Handbook excerpt (draft)	July 2005
	Southern Health Policies and Procedures: Emergency Services #CN-036	03/03/2005 revised
ER 6	Southern Health Policies and Procedures: CareNet Members Requesting a Second Opinion #CN- 021	01/01/2005 effective
	Member Handbook excerpt (draft)	07/2005 revised
ER 7	Member Handbook excerpt (draft)	07/2005 revised
	Coventry Health Care Policies and Procedures: Privacy Compliance Program #HR- 001	03/31/2004
	Privacy Compliance Program Business Unit Privacy Leader Annual Tasks	Undated
QA 3	Southern Health Policies and Procedures: CareNet Members Requesting a Second Opinion #CN- 021	01/01/2005 effective
QA 4	Southern Health Policies and Procedures: Out of Network Coverage #UM- 141	04/04/2005 effective
QA 8	Southern Health Policies and Procedures: Preauthorization #UM-004	04/04/2005 revised
QA 13	Southern Health Policies and Procedures: Utilization Management Decision Making & Time Frame Standards #UM- 014	04/04/2005 revised

Summary of Documents Reviewed		
Element	**Document**	**Date**
QA 14	Southern Health Policies and Procedures: Utilization Management Decision Making & Time Frame Standards #UM- 014	04/04/2005 revised
QA 20	Southern Health Policies and Procedures: Processing Disenrollment for CareNet Members #CN- 019	05/12/2005 revised
QA 29	Southern Health Policies and Procedures: Secure E-Mail Process #HP-019	04/26/2005 effective
GS 1	Southern Health Policies and Procedures: UM Appeal Process CareNet Members #CN-010	04/21/2005 effective
	Southern Health Policies and Procedures: Administrative Appeals Process CareNet Members #CN- 011	04/21/2005 effective
	Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members #CN- 012	04/21/2005 effective
GS 4	Southern Health Policies and Procedures: UM Appeal Process CareNet Members #CN-010	04/21/2005 effective
	Southern Health Policies and Procedures: Administrative Appeals Process CareNet Members #CN- 011	04/21/2005 effective
	Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members #CN- 012	04/21/2005 effective
	Member Handbook excerpt (draft)	07/2005 revised
GS 6	Southern Health Policies and Procedures: UM Appeal Process CareNet Members #CN-010	04/21/2005 effective
	Southern Health Policies and Procedures: Administrative Appeals Process CareNet Members #CN- 011	04/21/2005 effective
	Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members #CN- 012	04/21/2005 effective
	Member Handbook excerpt (draft)	07/2005 revised
GS 8	Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members #CN- 012	04/21/2005 effective
GS 9	Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members #CN- 012	04/21/2005 effective
	Member Handbook excerpt (draft)	07/2005 revised
GS 10	Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members #CN- 012	04/21/2005 effective
	Southern Health Policies and Procedures: UM Appeal Process CareNet Members #CN-010	04/21/2005 effective
	Southern Health Policies and Procedures: Administrative Appeals Process CareNet Members #CN- 011	04/21/2005 effective
GS 11	Southern Health Policies and Procedures: UM Appeal Process CareNet Members #CN-010	04/21/2005 effective
	Southern Health Policies and Procedures: Administrative Appeals Process CareNet Members #CN- 011	04/21/2005 effective
	Southern Health Policies and Procedures: Fast (Expedited) Appeal Process CareNet Members #CN- 012	04/21/2005 effective